MARYLAND HEALTH CARE COMMISSION

Summary of the Healthcare-Associated Infections (HAI) Advisory Committee Meeting

March 24, 2010

Committee Members Present
Beverly Collins, MD, MBA, MS (via telephone)
Sara E. Cosgrove, MD, MS
Jacqueline Daley, HBSc, MLT, CIC, CSPDS
Elizabeth P. (Libby) Fuss, RN, MS, CIC
Wendy Gary, MHA (via telephone)
Anthony Harris, MD, MPH
Andrea Hyatt (via telephone)
Debra Illig, RN, MBA, CLNC (via telephone)
Lynne V. Karanfil, RN, MA, CIC (via telephone)
Jean E. Lee, Pharm.D., BCPS
Peggy A. Pass, RN, BSN, MS, CIC
Carol Payne (via telephone)
Michael Anne Preas, RN, BSN, CIC
Brenda Roup, PhD, RN, CIC
Jack Schwartz, Esq.
Kerri Thom, MD, MS
Renee Webster
Lucy Wilson, MD, Sc.M

Committee Members Absent
Maria E. Eckart, RN, BSN, CIC
William Minogue, MD
Patricia Swartz, MPH, MS

Commission Staff
Pam Barclay
Theressa Lee
Mohamed Badawi
Robin Hudson
Eileen Witherspoon
Judy Wright

Public Attendance
Mary Andrus, APIC Consulting Services, Inc.
Marla Dalton, APIC Consulting Services, Inc.
Katie Henry, Department of Health and Mental Hygiene
Patricia Lawson, RN, MS, MPH, CIC, Department of Health and Mental Hygiene
Patty Leeman, APIC Consulting Services, Inc.
Beverly Miller, Maryland Hospital Association

1. Call to Order

Pam Barclay, Director, Center for Hospital Services, called the meeting to order at 1:00 p.m. and stated all who were present in person and on the phone.

2. Review of Previous Meeting Summary (February 24, 2010)

The previous meeting summary was approved with a minor grammatical correction identified on page 2.

3. Presentation: Central Line-Associated Blood Stream Infections (CLABSI) Data Quality Review and Chart Audit

Ms. Andrus Project Clinical Consultant for the CLABSI audit discussed the objectives of the project as well as the responsibilities of staff involved. She reported that every Maryland hospital was reviewed based on the option selected by the HAI Advisory Committee. Facilities were contacted for positive blood cultures which were submitted to MHCC electronically. Ms. Andrus discussed how ICUs and cases were identified for the audit and summarized the process for training the auditors.

In discussing the results of the audit, she stated that 202 records were reviewed: 73 of these were hospital reported CLABSIs, of which the auditors confirmed 67 as CLABSIs (91.7%); 129 records were not reported as CLABSIs, of which auditors confirmed 121 as non-CLABSIs (93.8%). In total, 14 cases were reported incorrectly. Ms. Andrus reviewed the 14 discrepant cases and summarized how the cases were analyzed and resolved. CDC was contacted for advice on a few cases that were challenging and not straightforward. For example, there was discussion about common skin contaminants and Ms. Andrus said if the organism is not on the CDC list of common skin contaminants, it should be counted.

Ms. Andrus spoke about the interview process that was conducted at the conclusion of the audit to determine if denominator data was collected correctly and reviewed the interview questions and responses. For some hospitals, electronic collection of patient days seems appropriate and corresponds with NHSN protocol. The collection of central line days was inconsistent and incorrect in some hospitals interviewed. Ms. Andrus offered the following recommendations for future training opportunities: review primary vs. secondary bloodstream infections criteria; create a training module for collection of device (central line) days with emphasis on protocols for using electronic data sources; and, provide methods of quality control for counting central line days.

Ms. Andrus took questions from the HAI Advisory Committee members. Ms. Fuss suggested MHCC staff look at present on admission positive blood cultures, to cut down the number of possible blood cultures to review for future audits. Ms. Barclay said the Advisory Committee would be discussing how to enhance the audit process going forward. Dr. Harris said the point of the audit was to review every hospital and to have the auditors stress the importance of the definitional aspects of reporting CLABSIs. Ms. Andrus said the auditors did provide some education and guidance during the exit interview process. Dr. Harris said the rate of misclassification is high at 6% and 9% for a rare event outcome. Dr. Wilson asked how Maryland's rates compared to other states. Ms. Andrus said that detailed data are not available for other state audits and other audits were not designed the same way.

In response to a question by Ms. Fuss, Ms. Andrus said many of the auditor-identified CLABSIs that were not originally reported by the hospitals were often reported as secondary bloodstream infections with no primary infection site identified. Ms. Daley suggested the misclassification seen in the audit could be a larger scale problem at the national level. Ms. Andrus said she recommends the final audit report be shared with NHSN. Ms. Preas asked if MHCC has plans for training for IPs. Ms. Barclay said the results in the report will be shared with the IPs and also a future training will be planned. Dr. Cosgrove asked when public reporting would be take place and how the data will be reported. She suggested the greatest outliers should be noted, not just ranking the hospitals by highest to lowest rate. Ms. Barclay said staff will come back to the Advisory Committee with recommendations on public

reporting for further discussion. Ms. Barclay indicated that the data would probably be publicly reported in early fall.

Dr. Harris mentioned the upcoming CDC report that will include state level SIRs (standardized infection ratios) for CLABSI data reported through NHSN. Ms. Daley said the results of the audit may show a lack of infection prevention staffing as cuts continue at some hospitals. Ms. Andrus believes the problem lies, in part, with IPs not realizing the importance of the denominator data. They are more concerned with reporting the CLABSI events.

4. Continued Discussion on Establishing Maryland HAI Prevention Targets

Ms. Barclay discussed the need to set prevention targets for CLABSI rates. Handouts were distributed that compare preliminary data on CLABSI rates for Maryland ICUs with national CLABSI rates. Ms. Barclay reviewed the handouts and said the purpose of the comparison was to replicate the existing annual NHSN report. She said certain ICU types were left out due to small numbers. She discussed the caveats with the data including using the HSCRC classification for major teaching status. She said the 5 year target within the HHS Action Plan is to reach the 25th percentile of the national CLABSI rates. The purpose of this CLABSI data included in the handout is for establishing a baseline to begin tracking improvement over time.

Dr. Harris said the CDC report will compare data periods to emphasize progress over time. Confidence intervals will be stressed and the median and mean will be provided. Ms. Barclay said the ICU categories are based on how hospitals reported into NHSN. Ms. Daley suggested the group create an action plan after this data is reported. Ms. Barclay agreed with the suggestion. Dr. Harris said the CDC report was tentatively scheduled to be published in the *Morbidity and Mortality Weekly Report* in April. Dr. Harris said hospitals can follow checklists or bundles and still have high CLABSI rates according to several studies. It is not clear cut how to get the CLABSI rate to zero. Dr. Harris said it would be good to know how many hospitals are currently using the bundle in Maryland.

Ms. Fuss commented that the audit is important in that it supports IP efforts in their hospitals, especially when other hospital staff members disagree with IP findings while doing surveillance. Ms. Barclay asked the HAI Advisory Committee members to think about prevention targets for a future discussion.

5. Other Business

Establishment of Subcommittees

Ms. Barclay announced that four subcommittees will be set up to assist the Advisory Committee and will focus on: process and outcome measures, infection prevention, IP training and workforce, and lab reporting.

Initiation of SSI Data Collection

Ms. Barclay reminded the Committee that the start date for SSI data collection is July 1, 2010. A training session for hospitals will take place on May 6, 2010 at the Maryland Hospital Association offices.

Status of Prevention Collaboratives

Hospital Hand Hygiene Collaborative

Ms. Barclay stated that a meeting was taking place at the same time for the Hand Hygiene collaborative and that the project is progressing well.

Acinetobacter Collaborative

Dr. Roup reported that an invitation to IPs was sent out to solicit participation in the acinetobacter project. She said she received feedback from 15 hospitals expressing strong interest and other facilities responded positively. She reiterated that the project was public health surveillance in response to a public health threat and IRB approval is not needed.

6. Adjournment

The meeting adjourned at approximately 3:15 p.m. The next meeting is scheduled for April 28, 2010.